2023-2024

LEE YOUTH ASSOCIATION

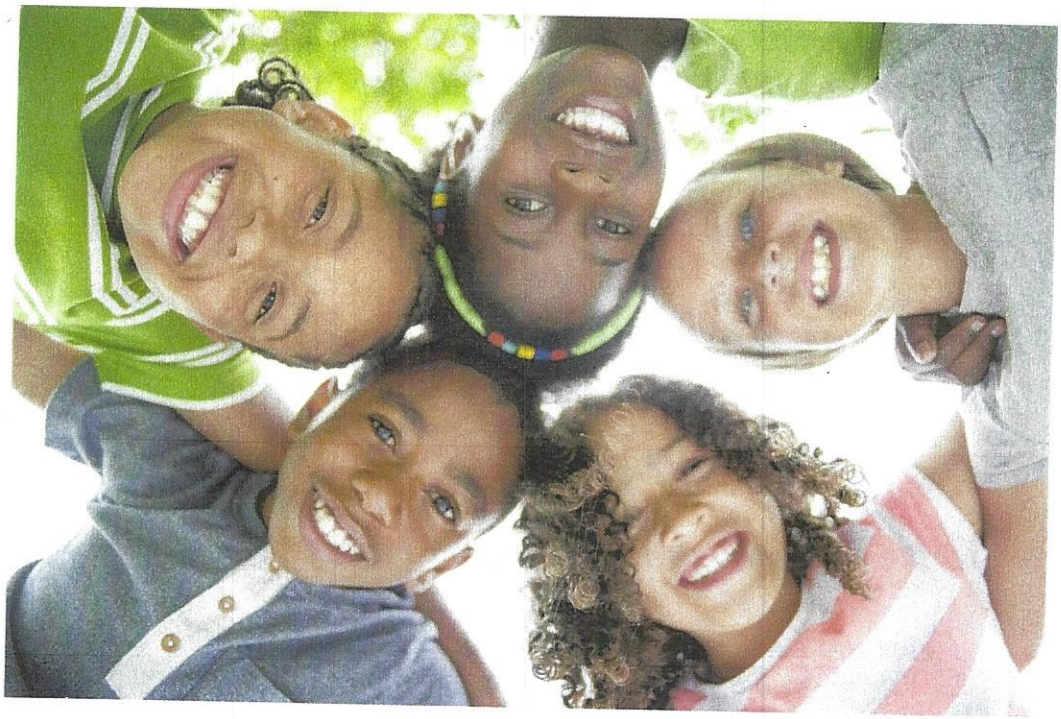
GRADES K-2 and 3-6

AFTER SCHOOL PROGRAM

(at the Lee Elementary School)

(children are separated into

two programs by grade)



Lee Youth Association

PO Box 115, 480 Pleasant Street

Lee MA 01238

Phone 413-243-5535, Fax 413-243-5536

www.leeyouthassociation.org

After School Program
2023-2024 School Year

1. *The LYA After School Programs are held at the LES - the children will go tothe cafeteria immediately after school for a snack (please send an extra*
   snack in your child's lunch). They may remain in the cafeteria, go to the gym or go outside (depending on the weather).
2. *The program runs from 3:00* to *5:30 (you must pick up* no *later than 5:30).If you are late, there will be a $5 per minute (that you are late) charge added to your bill.*
3. *You must enter through the front door for pick up as we could be in any one of three places at pick up time.*
4. *Tuition is $13 per day.*
5. *Tuition for vacation days is $29/day and half days is $19/day. Sign-upsheets will be at the after school programs prior to these days.*

Please circle the days that your child will attend

M T W TH F

First day will be August 30th

Start Date: _____

Today's Date: _____

Date of your child's last physical _____

I give the LYA permission to take pictures of my child to be used on the LYA website and other marketing materials.

I give the LYA staff permission to take my child on a walk around theschool grounds (weather permitting)

Parent's Signature _____

The Commonwealth of Massachusetts
Department of Early Education and Care

Child's Enrollment Form

Child Information

Child's Name:_____ Date of Birth:_____

Age at Admission:_____ Date of Admission:_____

Child's Home Address:_____

Home Phone Number:_____

Primary Language:_____ Identifying Marks:_____

Eye Color:_____ Hair Color:_____ Skin Color:_____

Sex:_____ Height:_____ Weight:_____

Parent/Guardian Information

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Additional Information

Child's Physician:_____

Address:_____ Phone Number:_____

Allergies/Special Diets?_____

Individual Health Plan for child with a chronic health condition? If yes, please attach._____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach._____

Special limitations or concerns? _____

_____

School Age Only

Current School:_____

School Address:_____ School Phone Number:_____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school. ***Parent/Guardian initials:***

_____ _____

Parent/Guardian Signature **Date**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)
Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent /Guardian Signature Date (valid for one year)

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (applied to open wound/ broken skin)_____

My child has previously taken this medication_____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____Date_____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date_____
For topical, non-prescription NOT applied to open wound / broken skin (parent signature only)

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT PICK UP
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

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___SUPERVISED WALK
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___PROGRAM BUS/VAN
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___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION

Lee Youth Association's Tuition Automatic Payment Program

As per the requirement of the LYA Board of Directors, we need credit card or debit card information from individual families *enrolling as of July 2020* to ensure payment. Families are asked to enroll in automatic payment through either a credit card or a debit card option.

Please be advised that:

1. Payment is due on the first of the month for the month in advance [Example: Due on January 1 for January 1-31 tuition].
2. Failure to pay in *by the fifteenth of the month* may result in termination from our programs.
3. Snow days on a registered day are still billable and will not be credited.

Upon receipt of this letter, please select one of the options below for automatic payment:

_____ Credit card payment

_____ Debit card payment

Then complete the following information, sign, and return this form to Kathy Dyer, LYA Billing Manager:

Name on credit or debit card: _____

Credit/ debit card number: _____

Expiration date: _____

Street address and zip code: _____

If you have any questions, concerns, and/or updates, please contact Kathy Dyer by:

Phone: 413.243.5535 ext. 2

Email: [redacted]

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I have read the above policy and authorize the LYA to charge my credit/debit card on the first of the month for tuition for the month in advance.

Name: _____

Signature: _____

Date: _____